ARGUMENTS

Claims 1-6, 9-16, 18-20, 24-28 and 30-33 are on appeal. Please cancel Claims 1-33. Please add Claims 34-53. In accordance with 37 CFR 41.39(b), because the Examiner's Answer contains a new ground of rejection, appellants request that prosecution be reopened before the primary examiner. *See* Examiner's Answer at p. 5. No new matter is introduced.

Substance of Interview – December 23, 2008

Applicants appreciates the discussion with Examiner Pass and Examiner O'Connor and their helpful comments during a telephonic interview with the undersigned and Joseph A. Capraro, Jr. on December 23, 2008. The interview included a discussion of new claim 34. In particular, new claim 34 was discussed in view of the cited prior art U.S. Patent Number 6,453,297 to Burks et al. (hereinafter "Burks"), U.S. Patent Number 6,047,259 to Campbell et al. (hereinafter "Campbell"), and U.S. Patent Number 5,253,164 to Holloway et. al. (hereinafter "Holloway"). It was indicated that new claim 34 had merit, but a new search would be required.

Support for New Claims

Independent Claims	Support can be found at least at:
Claim 34	
34. (New) A computerized method for managing a medical practice comprising:	Previously pending claims; [002]
storing a plurality of insurance rules comprising one or more classes of rules, each class of rules being associated with one of a plurality of payor servers;	Previously pending claims; FIG. 2A; [0048], [0052], [0108]
receiving data indicative of a completed claim submission for a claim from a medical practice client, the claim being associated with a payor server; and	Previously pending claims; FIGS. 3E-3F and 7A; [0085-0087], [0100]
automatically interacting with the completed claim submission to correct an error by applying one or more rules from a class of rules associated with the payor server, wherein the one or more rules comprises a new rule, an updated rule, or both received from the payor server, the interacting step comprising:	Previously pending claims; FIGS. 3E-3F; FIG. 8C; [0085-0094], [0104], [0113-0116]
associating a first claim status with the	Previously pending claims;

completed claim submission indicative of the claim not satisfying one of the one or more rules;	[0088], [0113-0114]
transmitting data indicative of a claim edit screen to the medical practice client, the claim edit screen comprising a claim edit section for editing the completed claim submission;	Previously pending claims; FIGS. 7D-7E; [0089], [0104], [0114]
receiving data indicative of an updated completed claim submission from the medical practice client; and	Previously pending claims; FIGS. 7D-7E; [0089-0091], [0104], [0114]
associating a second claim status with the updated completed claim submission indicative of the updated completed claim submission satisfying all of the one or more rules.	Previously pending claims; [0088-0091], [0094], [0113-0114]
Claim 35	
formatting the updated completed claim submission into information having a form acceptable to the payor server using claim formatting rules; transmitting the information to the payor server; and associating a third claim status with the updated completed claim submission indicative of the information being transmitted to the payor server.	Previously pending claims; [0053], [0091], [0114-0015]
Claim 37	
receiving data indicative of a new rule, an updated rule, or both from the payor server; and automatically updating the class of rules associated with the payor server to reflect the received data.	Previously pending claims; [0050]

Support for dependent claim 36 can be found at least at [0115]. Support for dependent claim 38 can be found at least at [0087]. Support for dependent claim 39 can be found at least at [0087]. Support for dependent claim 40 can be found at least at [0048]. Support for dependent claim 41 can be found at least at [0052]. Support for dependent claim 42 can be found at least at [0059]. Support for dependent claim 43 can be found at least at [0060]. Support for dependent claim 44 can be found at least at [0088] and [0091]. Support for dependent claim 45 can be found at least at [0088-89]. Support for dependent claims 46 and 47 can be found at least at [0093]. Support for dependent claims 48 and 49 can be found at least at [0094]. Support for dependent claim 50 can be found at least at [0091], [0093], and [0095]. Support for dependent

claim 51 can be found at least at [0100]. Support for dependent claim 52 can be found at least at [0114]. Support for dependent claim 53 can be found at least at [0116].

Claim Rejections – 35 U.S.C. § 112, First Paragraph

Applicants thank the examiner for withdrawing the rejections of claim 1, 15, 20, 27, and 28 under 35 U.S.C. § 112.

(New Grounds) Claim Rejections – 35 USC §112, Second Paragraph

Claim 20 was newly rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which Applicants regard as the invention. Applicants have cancelled claim 20, rendering this rejection moot.

Claim Rejections - 35 U.S.C. § 103

Claims 1-6, 13-16, 18-20, 24-28, and 30-33 stand rejected under 35 U.S.C. § 103(a) as being unpatentable over Burks and Campbell in view of Holloway. Claims 9-11 stand rejected under 35 U.S.C. § 103(a) as being unpatentable over Burks and Campbell and Holloway as applied to claims 1 and 2, and further in view of U.S. Patent Number 5,995,939 to Berman et al. (hereinafter "Berman"). Claim 12 under 35 U.S.C. § 103(a) as being unpatentable over Burks and Campbell and Holloway as applied to claims 1 and 2, and further in view of U.S. Patent Number 6,757,898 to Ilsen et al. (hereinafter "Ilsen").

New independent claims 34, 35, and 37 recite a computerized method for managing a medical practice. A plurality of insurance rules comprising one or more classes of rules are stored, each class of rules being associated with one of a plurality of payor servers. Data indicative of a completed claim submission for a claim is received from a medical practice client, the claim being associated with a payor server. The completed claim submission is automatically interacting with to correct an error by applying one or more rules from a class of rules associated with the payor server, wherein the one or more rules comprises a new rule, an updated rule, or both received from the payor server. The interacting step includes associating a

first claim status with the completed claim submission indicative of the claim not satisfying one of the one or more rules. The interacting step also includes transmitting data indicative of a claim edit screen to the medical practice client, the claim edit screen comprising a claim edit section for editing the completed claim submission. The interacting step also includes receiving data indicative of an updated completed claim submission from the medical practice client. The interacting step also includes associating a second claim status with the updated completed claim submission indicative of the updated completed claim submission satisfying all of the one or more rules. In contrast, none of the prior art of record teach or suggest these features.

New independent claim 35 recites, in addition to the elements of claim 34, formatting the updated completed claim submission into information having a form acceptable to the payor server using claim formatting rules, transmitting the information to the payor server, and associating a third claim status with the updated completed claim submission indicative of the information being transmitted to the payor server. New independent claim 37 recites, in addition to the elements of claim 34, receiving data indicative of a new rule, an updated rule, or both from the payor server, and automatically updating the class of rules associated with the payor server to reflect the received data.

Burks discloses creating *error messages* when a data record does not contain the proper type and sending the error message to a computer station so that the computer station is informed of the improper data. Burks at col. 9, ll. 46-52; col. 12, l. 56-67; col. 13, ll. 1-30. Specifically, Burks states if an erroneous data type is detected, an error flag is set, and message identifying information is placed in an error record that is sent to the computer station that sent the erroneous message. Burks at col. 9, ll. 46-50; col. 12, ll. 56-66. Burks also discloses receiving data messages from a trading partner and then generating error messages which are sent to the trading partner "to inform them of erroneously transmitted messages." Burks at col. 7, ll. 20-34; col. 15, ll. 19-24. As such, the error message is not being utilized to automatically update an insurance claim, but is instead being used to send a message regarding an error back to the healthcare provider (i.e., the computer station) or the trading partner. This error message only informs the provider of an error. It does not update the claim or the insurance rule.

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Stated differently, the message disclosed by Burks represents the problem Appellant's invention was designed to solve. Burks discloses checking for a proper type. Burks fails to teach or suggest storing a plurality of insurance rules comprising one or more classes of rules, each class of rules being associated with a particular payor server. Further, Burks does not teach or suggest receiving and automatically interacting with a completed claim submission to correct an error by applying one or more rules from a class of rules associated with the payor server, wherein the one or more rules comprises a new rule, an updated rule, or both received from the payor server. Furthermore, Burks only discloses setting a flag to indicate an erroneous data type is detected. Burks fails to teach or suggest associating a first claim status with the completed claim submission indicative of the claim not satisfying one of the one or more rules, transmitting data indicative of a claim edit screen to the medical practice client comprising a claim edit section for editing the completed claim submission, receiving data indicative of an updated completed claim submission from the medical practice client, or associating a second claim status with the updated completed claim submission indicative of the updated completed claim submission satisfying all of the one or more rules.

Burks fails to teach or suggest "formatting the updated completed claim submission into information having a form acceptable to the payor server using claim formatting rules; transmitting the information to the payor server; and associating a third claim status with the updated completed claim submission indicative of the information being transmitted to the payor server" as claimed in new independent claim 35. Burks discloses receiving a medical claim from a healthcare provider station, reorganizing the information into a generic medical claim record format, and extracting the generic medical record that corresponds to a trading partner and formatting the record in a format that corresponds to a computer identification code that corresponds to the trading partner. Burks at col. 5, ll. 52-63; col. 8, ll. 34-47. Burks fails to teach or suggest formatting the actual updated completed claim submission using claim formatting rules, but instead requires first generating a generic medical claim record, which is later extracted and formatted.

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Campbell fails to cure the deficiencies of Burks. Campbell discloses a "system for tracking workflow through a medical facility . . ., managing medical exams of patients in the facility, and managing a treatment protocol[s] for the patients." Campbell at col. 1, ll. 51-53. Campbell discloses that the "computer is responsible for handling billing of clients" which includes receiving or confirming some form of payment from the client. Campbell at col. 7, ll. 13-15; col. 21, ll. 14-16. Campbell further discloses automatically adding service items completed during the visit to the client's invoice when the doctor completes the service on the therapy screen. Campbell at col. 15, ll. 47-51. However, Campbell does not receive any information from a third party (i.e., a payor server) which is utilized to update an insurance claim. Rather, "[t]he server removes the diagnosis from the rule out list, adds it to the tentative diagnosis, and determines which abnormal observations are linked to the diagnosis." *See* Campbell at col. 17, ll. 11-13. As such, the addition of service items and the movement of a diagnosis from the rule out list to the tentative diagnosis are not automatically occurring, but are based on actions by the doctor (i.e., doctor selects a diagnosis, provider team selects a service). Campbell at col. 18, ll. 28-32. Additionally, the rule out list in Campbell is a "list generated by the system . . . to select tentative diagnosis" of a patient and not rules for updating an insurance claim. *See* Campbell at col. 2, ll. 25-27; col. 16, ll. 66-67. Accordingly, Campbell merely discloses adding a service item based on a service and moving a diagnosis from one list to another list.

The Examiner's Answer states that "Burks and Campbell fail to explicitly disclose (j) automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server; and (k) automatically and repeatedly updating the one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the update rule, or both received from the payor server." *See* Examiner's Answer at p. 12. New independent claims 34, 35, and 37 recite "automatically interacting with the completed claim submission to correct an error by applying one or more rules from a class of rules associated with the payor server, wherein the one or more rules comprises a new rule, an updated rule, or both received from the payor server." New

independent claim 37 additionally recites "receiving data indicative of a new rule, an updated rule, or both from the payor server; and automatically updating the class of rules associated with the payor server to reflect the received data." Holloway fails to cure the deficiencies of Burks and Campbell.

Holloway discloses a cost effective automated data processing system for paying only appropriately coded claim amounts. See col. 3, ll. 6-9. A set of decision-making rules are used to assist the medical claims processor. While Holloway discloses that there is a need to "detect and correct" errors (See col. 2, ll. 14-16), Holloway does not teach or suggest correcting an error in the insurance claim as claimed in new claim 34. Rather, Holloway only determines whether to pay the submitted medical claim or claims; the "error corrected" is preventing an incorrect payment, not correcting an error in the insurance claim. See col. 2, ll. 5-16; and col. 3, ll. 63-68.

The Examiner's Answer states:

> Holloway teaches "[a]n example is the inclusion of ... [...] a physician or his or her billing company may submit a claim for payment for two procedures [...] ... [t]he computer program invokes a rule which has been specified that states that if code 44140 appears with another code in a particular range, which in this example includes 49000, the second code should be rejected [correcting an error] and only the first specified paid. The claims processor then rejects the payment code 49000, authorizes payment for code 44140 ... [...] ... Without such a program, the claims processor usually pays both code numbers" (emphasis added) (Holloway; column 3, lines 4567); Examiner interprets these teachings as a form of "correcting an error in the insurance claim."

See Examiner's Answer at p. 29. However, Holloway discloses that a user must enter various facts from the claims into the computer system, and the system runs the rules *against a knowledge base*, not the insurance claim itself. The user does not submit a completed claim submission, and rules are not run against a completed claim submission. *See* Holloway at col. 3, ll. 25-37; col. 4, ll. 27-28 and ll. 51-64. "The interpreter 5, using the rules of the present invention, interacts with the knowledge base 6 of the present invention ..." *See* Holloway at col. 4, ll. 56-58. Additionally, if the user did not enter sufficient information, the system prompts the user for additional information. *See* Holloway at col. 4, ll. 60-62. The system disclosed by

Holloway does not transmit a claim edit screen to the medical practice client comprising a claim edit section for editing the completed claim submission.

For example, Holloway discloses an exemplary interaction with the system "Computer Prompt: Please enter all CPT-4 procedure codes appearing on the claim, or, if a code is absent, look up the code(s) using the CPT-4 procedure manual or another aid, and enter the codes. User Enters: 46934 … PATH ONE: IF CHARGE IS GREATER THAN PAYMENT LIMIT FOR 46500: … Allow no higher payment than the maximum allowable payment for code 46500." *See* Holloway at col. 27-30, Example 10. Holloway fails to teach or suggest automatically interacting with a completed claim submission. Specifically, Holloway fails to teach or suggest "receiving data indicative of a completed claim submission for a claim … automatically interacting with the completed claim submission to correct an error by applying one or more rules from a class of rules associated with the payor server, wherein the one or more rules comprises a new rule, an updated rule, or both received from the payor server, the interacting step comprising: associating a first claim status with the completed claim submission indicative of the claim not satisfying one of the one or more rules; transmitting data indicative of a claim edit screen to the medical practice client, the claim edit screen comprising a claim edit section for editing the completed claim submission; receiving data indicative of an updated completed claim submission from the medical practice client; and associating a second claim status with the updated completed claim submission indicative of the updated completed claim submission satisfying all of the one or more rules" as claimed in new independent claims 34, 35, and 37.

Additionally, Holloway fails to teach or suggest "storing a plurality of insurance rules comprising one or more classes of rules, each class of rules being associated with one of a plurality of payor servers" and "wherein the one or more rules comprises a new rule, an updated rule, or both received from the payor server" as disclosed in new independent claims 34, 35, and 37. The Examiner's Answer states:

> and "the PROCESS database 17 is appended to the HISTORY database 40 for recordkeeping purposes and for future use as a means to study these "case histories" and refine, update and change the rules and the knowledge base Interpreter" (Holloway; column 10, lines 3-7) and "a programmed computer system and a method of programming a computer system so that a knowledge

> base interpreter and <u>a set of rules may facilitate the classification and</u>
> <u>authorization of payment [from payors]</u> to health care providers. Since the
> invention resides in a programmed computer of the automatic programming
> category, the development of this HISTORY database 40 may lead to the
> development of <u>new rules</u> and a growth and refinement of the knowledge base
> interpreter 5" (emphasis added) (Holloway; column 10, lines 51-60). Examiner
> interprets these teachings to teach a form of "automatically and repeatedly
> interacting with the insurance claim to correct an error by applying a new rule, an
> updated rule, or both received from the payor server."

See Examiner's Answer at p. 27, emphasis in original. However, Holloway only discloses a single CodeReview product that interacts with one entity. Holloway at col. 4, ll. 25-27. The CodeReview product has a knowledge base of facts and a knowledge base interpreter which stores the rules and applies the knowledge base using the rules. Holloway at col. 3, ll. 30-35. Holloway does not teach or suggest how the rules are refined and or updated. Holloway fails to teach or suggest any more than a third party which studies the case histories from the history database at a later point in time to manually effectuate new or updated rules. Holloway at col. 10, ll. 3-7. Thus, there is only one collection of rules, all the rules apply to the user of the CodeReview product, and the new or updated rules are not received from a payor server.

Further, Holloway fails to teach or suggest "receiving data indicative of a new rule, an updated rule, or both from the payor server" and "automatically updating the class of rules associated with the payor server to reflect the received data" as recited in new independent claim 37. As indicated in the quoted passage from the Examiner's Answer above, Holloway generally states that the PROCESS database is appended to the HISTORY database for future use "as a means to "refine, update and change the rules," which may lead to the development of new rules. However, Holloway fails to teach or suggest receiving data indicative of a new rule or an updated rule from *the payor server*. The quoted passage above also recites that Holloway discloses that "a set of rules may facilitate the classification and authorization of payment [from payors]..." However, receiving authorization of payment, even if such payment is from payors, fails to teach or suggest receiving data indicative of a new rule or an updated rule from the payor server. Additionally, Holloway fails to teach automatically updating a class of rules associated with the payor server. Holloway only discloses appending the PROCESS database to the

HISTORY database for future use as a means to study the "case histories." As such, Holloway requires subsequent and non-automatic analysis of the case histories in order to create and update rules for the system.

Neither Ilsen nor Berman cure the deficiencies of Burks, Campbell, and Holloway. Ilsen discloses a "system, [which] provides an automated service to patients, through which access to their own doctor is provided over the Internet without additional work for the doctor's office because it is based upon existing records." Col. 4, lines 24-29. Furthermore, Ilsen discloses that the system provides information "for simply inquiries and follow-up instructions, for prescription refill and appointment requests, and for directions to the office, laboratory, radiologist or specialist's office, general information and the like." Col. 9, lines 33-37. Berman teaches an email-based system wherein personnel at the client site compose service requests and email them directly to the sponsors, upon which sponsors then receive the email messages in an email inbox, perform the request manually, and then send a response email. Col. 3, lines 44-52.

For at least these reasons, claims 34, 35, and 37 are patentable as they are neither anticipated nor obvious in view of the cited art of record. By virtue of at least its dependency upon claim 35 and the additional features recited therein, claim 36 is also patentable. Furthermore, by virtue of at least their dependency upon claim 34 and the additional features recited therein, claims 38-53 are also patentable.

CONCLUSION

Applicants' discussion of particular positions with the Examiner during the telephonic interview of December 23, 2008 does not constitute a concession with respect to any positions that are not expressly contested by the Applicants. Applicant's emphasis of particular reasons why the claims are patentable does not imply that there are not other sufficient reasons why the claims are patentable.

In view of the foregoing remarks and the inability of the prior art, alone or in combination, to anticipate, suggest or make obvious the subject matter as a whole of the invention disclosed and claimed in this application, all the claims are believed to be in a condition for allowance, and notice thereof is respectfully requested. If the Examiner feels that a telephone conference would expedite prosecution of this case, the Examiner is invited to call the undersigned.

Respectfully submitted,

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